S. No. 300
. 10-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38591

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10210

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (In this place) 22
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 1014 Chouteau Ave., 2729

3. NAME OF DECEASED (Type or Print) a. (First) BRUNO b. (Middle) c. (Last) HASENRITTER

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13th, 1950

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH 11/28/1876

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Robert Hasenritter

13b. MOTHER'S MAIDEN NAME Elizabeth unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS M. Renard

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Larynx with metastases — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1948

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Larynx

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 161X

22. *I hereby certify that I attended the deceased from* 8/23/50, 19___, *to* 11/13/50, 19___, *that I last saw the deceased alive on* 11/13/50 19___, *and that death occurred at* 7:00PM m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph Warren West, M. D. (Degree or title)

23b. ADDRESS 1515 Lafayette Ave.,

23c. DATE SIGNED 11/14/50

24a. BURIAL, CREMATION, REMOVAL (Specify) C

24b. DATE 11-30-50

24c. NAME OF CEMETERY OR CREMATORY CITY CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. NOV 30 1950

REGISTRAR'S SIGNATURE J. B. Lacater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Ryan's Son, Arend

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was **embalmed by me, or by**.....

.....,

working under my personal supervision. Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.